BQIS POST-TRANSITION QUALITY ASSURANCE CHECKLIST

Name of Individual Transitioning: _____ Date of checklist visit: _____

Name of individual:	Names of BQIS/BDDS staff performing this checklist (print):
New Residential Provider:	Signature of BQIS/BDDS Representative completing this form:
Home Address & Phone #:	Date of visit for transition QA Checklist:_(phone)__ _____ Check one: 7-day ☐ 30-day ☐ 60 –day 90-day ☐ other
Setting: SL ☐ SGL☐ Other (describe below):	Name & phone # of Case Manager (SL) QMRP (SGL):
Date resident moved into home:	Name & phone # of Residential Provider contact person:
Previous Residential Provider/SOF:	Date of Individual Support Plan used for this checklist:

- **Prior to conducting the survey** – check to see if any incidents have been reported; attach a copy of those incidents and follow up to this survey form. Note in question 45 if any incident reports do not have appropriate follow up submitted.
- For the 7-day post-move visit, the existing ISP should still be in place regardless of type of placement setting. For the 30 day post-move visit, at a minimum, a meeting should be scheduled to review the existing ISP for Individuals moving into supported living setting, and an IPP should be in place for Individuals moving into group homes. All questions below are to be scored using the **current** support plan (supported living) or individual program plan (group home) for the individual:

"Yes" = compliance with plan "No" = not in compliance with plan "N/A" = not a need in plan

NOTE: All "No" responses must include a narrative explaining the deficit

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1	Personal belongings in the home and available to Individual?				
2	Home adaptations in place? (list adaptations per PCP/ISP)				
3	Is an emergency telephone list present?*(N/A for Nursing Home Placement)*				
4	Medical equipment (ex: G-tube, C-pap, Oxygen) and adaptive equipment present (mealtime equipment, communicative devices, braces etc.)? (list equipment per transition plan/ISP)				
5	Home clean and hygienic?				
6	Safe storage of medications, cleaning supplies, knives and other potential hazards? *(N/A for Nursing Home Placement)*				
7	House, lot, yard, garage, walks, driveway, etc. free of environmental hazards? *(N/A for Nursing Home Placement)*				
8	Hot water no warmer than 110º Fahrenheit (or documentation that individual can safely mix water in ISP)?*(N/A for Nursing Home Placement)*				
9	Support plan updated? (enter date/time ISP meeting held. If planned & not yet held, enter date planned) *(N/A for Nursing Home Placement)*				
10	Transportation needs met? (describe how transportation needs are being met) *(N/A for Nursing Home Placement)*				
11	Are **ALL** issues identified as "High Risk" addressed appropriately, including staff training				

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	on each?				
12	Day program needs met and include meaningful work opportunities in community, based on preferences? (*N/A for Nursing Home Placement)*				
13	Other programs/training (other than day programs) relevant, functional, and based on preferences? *(N/A for Nursing Home Placement)*				
14	Opportunities for leisure based on preferences and promoting independence? *(N/A for Nursing Home Placement)*				
15	Opportunities for community experiences based on preferences and promoting independence? *(N/A for Nursing Home Placement)*				
16	Data collection processes in place and consistently completed? *(N/A for Nursing Home Placement)*				
17	If medications have been changed, is there documented justification for the changes? (list changes including dosages pre and post change. Include date of change)				
18	Medication administered and charted appropriately?(for Nursing Home placement, see guidelines)				
19	PRN Psychotropic medications reported and documented? *(N/A for Nursing Home Placement)*				
20	Adequate staff assigned and present? (describe staffing ratios)*(N/A for Nursing Home Placement)*				
21	Staff trained on Individual's medical needs				

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	including side effects of medications?				
22	Elimination patterns are monitored with input and output records kept, as applicable to individual's needs.				
23	Staff trained on Individual's dietary/nutritional /dining needs?				
24	Dining plans/dysphaga plans as applicable to the individual, documented and readily available for use by staff during consumption of food or fluids?				
25	Staff trained on Individual's personal hygiene needs?				
26	Staff trained on Individual's mobility and positioning needs?				
27	Staff trained on programs/plans for Individual's behavioral considerations and/or psychiatric needs/symptoms?				
28	Augmentative communication plan developed and implemented addressing primary need to communicate as indicated for individual, and staff trained on plan?				
29	Chronology of medical history available and shared with medical providers at time of consult or visit.				
30	Individual saw personal physician, with resulting recommendations reviewed by IST?(enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
31	System in place to follow up on results of blood tests.				
32	Individual saw personal dentist, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				

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33	Individual saw Psychiatrist, if indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
34	Individual saw neurologist, if indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
35	Individual saw behavior support provider, if indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
36	Any restrictive procedure has Human Rights approval and informed consent.				
37	Behavior Specialist trains lead and/or supervisory staff in behavior plan implementation and monitors implementation of plan.				
38	Individual saw OT, as indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
39	Individual saw PT, as indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
40	Individual saw Speech & Language Pathologist, as indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				

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41	Individual saw dietician, as indicated, with resulting recommendations reviewed by IST? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*				
42	Individual saw other Medical Specialist/s, as indicated, with resulting recommendations reviewed by IST? (enter specialty, name, phone # & appointment date/time. *(N/A for Nursing Home Placement)*				
43	Is the Individual adjusting to the home (i.e. - Is there a lack of any observed or reported problems such as poor eating, sleeping disturbance, depression, etc)?				
44	If there have been any recent illnesses, injuries or hospitalizations, did the individual receive appropriate medical care, with appropriate documentation? (list illnesses with dates) *(N/A for Nursing Home Placement)*				
45	If there has been a change in home, provider or Case Mgr., has the change resulted in positive outcomes for the Individual? *(N/A for Nursing Home Placement)*				
46	Does interview &/or documentation indicate adequate involvement from the Case Manager, if on waiver? *(N/A for Nursing Home or SGL Placement)*				
47	Does a review of the documentation indicate that the BDDS Incident Reporting Policy is being followed? (If no – document dates and types of incident on this form and assure that the incident is filed per the BDDS Incident and file an incident regarding the non-reporting of the initial incident.) *(N/A for Nursing Home Placement)*				

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48	Are all reported incidents resolved appropriately? *(N/A for Nursing Home Placement)*				
49	Are all needs (with emphasis on High-Risk needs) addressed at out-of-home habilitation service locations, including documentation of communication between the residential provider and providers at the out-of-home locations?				